

# INDIANA Epidemiology NEWSLETTER



Epidemiology Resource Center  
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Indianapolis, IN 46204  
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## Indiana Smallpox Pre-Event Vaccination Plan

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*Editor's Note: The information contained in this article  
is provisional and may change at any time.*

The Centers for Disease Control and Prevention (CDC), under the direction of President Bush, has mandated that states develop a plan to vaccinate volunteer public health and medical personnel who would investigate and manage a suspected case of smallpox. Any confirmed case of smallpox would indicate a bioterrorism event.

Indiana has been divided into ten bioterrorism preparedness districts (see map) as part of the CDC Bioterrorism Grant award. In the future, an ISDH public health administrator and field epidemiologist will be housed at one of the local health departments within each district. For the purpose of the smallpox pre-event vaccination plan only, a coordinating local health department (LHD) within each district has already been selected (see table). These coordinating health departments will provide information to other health departments within the district and help coordinate vaccination efforts.

Phase one of the pre-event vaccination plan includes only those who would be the first to respond to a case of smallpox. Public health response teams would conduct investigations and outbreak control for smallpox cases and include physicians, public health nurses, epidemiologists, and those trained as vaccinators. Health care response teams would treat and manage initial smallpox cases and suspects, and would be strategically placed around the state to

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adequately cover all areas. Response team members would be identified on the basis of their occupational duties. **The ISDH stresses that vaccination and participation on response teams is strictly voluntary.** The ISDH has requested 3000 doses of smallpox vaccine from CDC for phase one.

Phase two of the pre-event vaccination plan, following phase one, would include vaccinating those who would be most at risk of exposure to a case of smallpox. These individuals would include physicians, nurses, paramedics, emergency medical technicians, ambulance drivers, firefighters and police officers. Since this group would include a much larger number of people than phase one, many more vaccinators and vaccination clinics would be required. Those who were vaccinated in phase one may volunteer to be trained as vaccinators for phase two.

## **Hospital Preparedness**

As of December 16, 33 hospitals in the ten districts have volunteered to participate in phase one. Each of the coordinating LHDs is preparing a vaccination plan, and the teams assembled at the hospitals will be the smallpox health care responders for that hospital. Each district is to have at least one hospital with employees vaccinated against smallpox should the need arise. In phase two, all hospitals will be asked to vaccinate healthcare teams. The State Health Commissioner, in collaboration with the LHDs and the Indiana Hospital & Health Association, will make the final decision on those hospitals that will be included in phase one. This decision will be forthcoming in the near future so the coordinating LHDs can make their plans for the vaccination sites and process to be carried out when the vaccine is released.

## **Vaccination Clinics**

The *Protocol for Mass Prophylaxis* was released to all LHDs in 2001 and is also available on the ISDH website. General guidelines for conducting vaccination clinics and a diagram for clinic layout are included in this document. In addition, *Annex 3: Smallpox Vaccination Clinic Guide* of the *CDC Smallpox Response Plan and Guidelines* has been abstracted into a two-page checklist format for use as a planning guide for clinic operations.

LHDs will share responsibilities for clinic operations at sites within the district. At least two ISDH staff members will be available on site to assist with clinic operations. Wound care, daily inspection of vaccination site, change of dressing and "take" evaluation on Day 7 will need to be conducted by appropriate medical personnel at each site. Additional detailed information is included in the document referenced above.

ISDH personnel have prepared a *Decision-making Guide for Prospective Members of Indiana's Smallpox Response Teams*. This guide will assist in the screening process at clinic sites. It provides decision-making information on vaccination history, contraindications, household/workplace situations, and the ability to function as a team member. Another support item that ISDH is preparing is the "clinic kit." These will be delivered to each site and will contain many of the expendables listed in Annex 3 (Guide B1-39).

## **Training for Vaccinators**

To initiate the training, ISDH is sending two staff to CDC the week of December 16 to receive specific training on smallpox vaccine administration. When these nurses return, there will be an in-house train-the-trainer session for other ISDH staff members. These ISDH trainers will then be assigned to conduct on-site training for LHD personnel who have agreed to be vaccinators and for those who agree to assist with smallpox vaccination clinics. These trainings will be arranged with LHDs for the week of January 6, 2003 and will take place at LHDs.

Prior to the ISDH trainers arriving for the on-site trainings in January, the ten coordinating LHDs will receive a packet of information including videotapes that demonstrate the administration of the vaccine. The videos will also provide information on vaccination site care and evaluation of vaccine "takes." It is anticipated that trainers will also review with the LHDs their proposed clinic flow for smallpox vaccine administration. It is also anticipated that trainers will be available on-site during the first day of actual smallpox vaccine administration.

Additionally, ISDH is providing to all designated hospital staff, information on contra-indicated health situations that could rule-out a health care provider from receiving the smallpox vaccine. The information will also contain the potential minor side effects of the vaccine and the adverse reactions that may potentially occur.

## **Safety Monitoring and Adverse Events**

Smallpox vaccine safety monitoring is especially important, given the risk of smallpox virus introduction is uncertain, while the risks from the vaccine are not. With this in mind, the ISDH, in cooperation with the CDC and the local medical communities, are in the process of establishing a monitoring system that will be able to detect, assess, and treat individuals who suffer an adverse event as result of smallpox vaccination. The cornerstone of this system will be the identification of hospital assigned physicians (HAPs) who will be available locally to assess and advise on treatment of persons with adverse events. These HAPs will come from a variety of medical specialties including infectious disease, ophthalmology, dermatology, neurology, and allergy/immunology. The ISDH will also have a team of experts available for consultation if needed by the HAPs. In addition, the CDC will be providing 24/7 coverage from their Clinical Immunization Safety Assessment (CISA) network. The local HAPs and the ISDH team of experts, as well as other local physicians will have access to the CISA network after vaccine has been released to the states and administration has begun.

Two drugs, Vaccinia Immune Globulin (VIG) and cidofovir will be available to treat severe adverse events (eczema vaccinatum, progressive or severe generalized vaccinia, and accidental implantation if lesions are extensive). CISA will make recommendations for treatment with VIG and/or cidofovir, both of which are available under Investigational New Drug Protocols from CDC. In order for a physician to obtain either VIG or cidofovir for a patient, a consult with CISA will need to be conducted.

## ***Additional Information***

More information on the Indiana Smallpox Pre-Event Vaccination Plan, general information on smallpox and smallpox vaccine, and adverse events following vaccination can be found at the ISDH website at [www.in.gov/isdh](http://www.in.gov/isdh) and click on “emergency response.” General information on smallpox, vaccine and adverse events can also be found at the CDC website at [www.cdc.gov/bioterrorism](http://www.cdc.gov/bioterrorism). Specific questions from LHDs regarding the pre-event vaccination plan should be directed to the district coordinating health department or to Emily Loudon, ISDH, at 317-233-7121. Media inquiries can be directed to Margaret Joseph, ISDH, at 317-233-7315.

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## **An Outbreak of Outbreaks: Noroviruses Hit Hard Across Indiana**

Pam Pontones, MA  
ISDH Epidemiology Resource Center

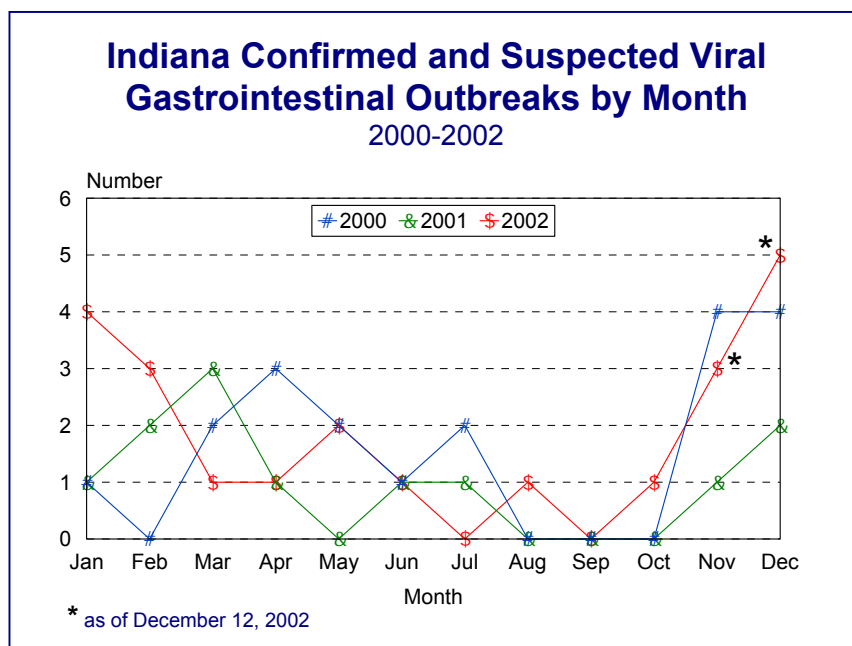
Such a tiny pathogen has generated big news recently, infecting hundreds of cruise ship passengers and forcing the closure of hospital wards across Canada, Great Britain, and Australia. Indiana residents are not immune, either. Since the beginning of November, six viral gastroenteritis outbreaks have been investigated in a variety of settings, including one restaurant, one outbreak in two sister hospitals, and six long-term care facilities. In addition, 23 suspected outbreaks have been reported from long term care facilities across the state. These are only the *reported* outbreaks.

Norwalk-like viruses, now classified under the genus *Norovirus*, cause an estimated 23 million infections, 50,000 hospitalizations, and 300 deaths among Americans each year<sup>1</sup> and are the leading cause of gastroenteritis outbreaks.<sup>2</sup> The classic symptoms of nausea, vomiting and diarrhea appear approximately 12-48 hours (average 30-36 hours) after exposure and resolve within approximately one to four days. Other symptoms may include abdominal cramps, headache, body ache, low-grade fever, and chills. Dehydration may result after prolonged vomiting and diarrhea, and reported deaths usually result from complications of dehydration or underlying medical conditions.

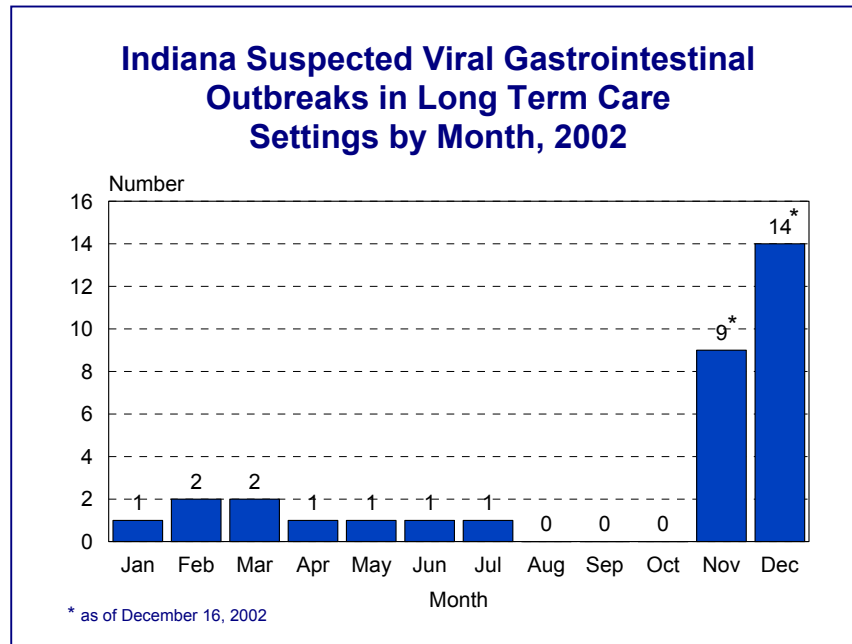
At least 23 types of noroviruses can infect humans. The virus is shed in stool and transmitted via the fecal-oral route. This occurs when someone uses the toilet and does not wash hands, then touches food, beverages, other people, or common surfaces or objects. Another means of transmission can occur when aerosols of vomitus are inhaled.<sup>2</sup> Fewer than 100 viral particles are needed to transmit infection, and the virus can remain inert on surfaces for several days. The virus can remain stable in chlorination levels up to 10 parts per million, survives freezing, and survives heating up to 60°C.<sup>1</sup>

Although infection from noroviruses can occur anytime of year, there is a seasonal peak that begins in November and continues throughout the winter months. This has been observed in Europe, where this illness is known as “winter vomiting”, and according to recent outbreak data, here in Indiana as well. Figure 1 shows the number of confirmed and suspected outbreaks of viral gastroenteritis investigated in Indiana from 2000-2002. In 2002, the ISDH Epidemiology Resource Center began conducting surveillance of incident reports of suspected viral gastrointestinal illness. Figure 2 shows the pattern of these reports received during the year. This seasonality may be due to the fact that greater numbers of people maintain closer physical contact indoors throughout the winter months, especially during the holiday season. Holiday travel may also play a role. Greater numbers of people traveling longer distances can effectively transmit infection throughout different areas of the US and across the globe, as witnessed by the recent infections among cruise ship passengers.

**Figure 1.**



**Figure 2.**



Even with the current seasonality, norovirus infection has been particularly prevalent this year. According to the Centers for Disease Control and Prevention (CDC), there may be a predominant emerging norovirus strain. Since January 2002, 21 outbreaks of acute gastroenteritis on cruise ships have been reported, compared with seven outbreaks reported in 2001. Nine of these outbreaks were confirmed as norovirus outbreaks by laboratory testing. According to genetic sequencing analysis, four of these outbreaks were caused by the same viral strain. In addition, of the 29 non-cruise ship norovirus outbreaks CDC confirmed this year, five were caused by the same strain found in the four cruise ship outbreaks. These outbreaks occurred in North Carolina, Kentucky, Georgia, and Utah. An additional five outbreaks caused by the same strain were also reported in Michigan. No sequencing data are currently available for the Indiana outbreaks.

As recent outbreaks have indicated, the public health implications of norovirus infection are great. First, the virus requires a very low inoculating dose to transmit infection. Second, several strains exist, so exposure to one strain will not protect against exposures to other strains. Third, immunity appears to last only a few months, so it is possible to eventually be reinfected with the same strain. Fourth, the virus is extremely environmentally stable and can remain infective on surfaces for several days. Finally, people may continue to shed virus up to two weeks after symptoms have ceased.

For these reasons, introduction of Norwalk-like virus into closed populations, such as hospitals and long term care settings (and cruise ships), can pose significant infection control challenges. Information regarding infection control measures in hospital and long term care settings may be found in a recent article in the *Journal of Hospital Infection* (2000) 45:1-10, "Management of hospital outbreaks of gastro-enteritis due to small round structured viruses".<sup>3</sup>

In any setting, there are several ways to help prevent the spread of infection:

- Wash hands thoroughly with soap and running water
  - after using the restroom
  - after changing diapers
  - after assisting someone to use the restroom
  - after assisting someone who is ill
  - before preparing food
  - before eating

- Exclude ill people from preparing food or providing medical or childcare.
- Exclude ill children from daycare and school.
- Do not attend work or social events while ill.

**The ISDH actively investigates outbreaks of viral gastroenteritis. To report an apparent outbreak, please call the ISDH Epidemiology Resource Center at (317) 233-7125.**

## References

<sup>1</sup>Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*, “Outbreak of Acute Gastroenteritis Associated with Norwalk-Like Viruses Among British Military Personnel – Afghanistan, May 2002.” June 7, 2002 / 51(22);477-479.

<sup>2</sup>Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*, “Outbreaks of Gastroenteritis Associated with Noroviruses on Cruise Ships – United States, 2002.” December 13, 2002 / 51(49); 1112-1115.

<sup>3</sup>Chadwick, P.R., et al. Report of the Public Health Laboratory Service Viral Gastro Enteritis Working Group: Management of hospital outbreaks of gastro-enteritis due to small round structured viruses. *Journal of Hospital Infection* (2000) 45: 1-10.

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## HIV/AIDS Case Report Form Collects Additional Information

Jerry V. Burkman, RN, MPH  
ISDH HIV/STD Division

The HIV/AIDS case report forms, both adult and pediatric, will begin to collect additional information starting January 1, 2003. The federal government requires that the previous collection of race/ethnicity as one item be separated into race and ethnicity. The only ethnicity being collected is Hispanic/Latino or Not Hispanic/Latino. Each reporter is to select one of these two options. Race has five options, with the ability to select one or more than one. The race options include: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian/or Other Pacific Islander, and White. The order is alphabetical.

Coinfections with HIV have become a significant factor in targeting HIV prevention programs and HIV medical services. They may also impact the treatment of HIV and the coinfection. Additional information will be collected regarding diagnosed mental illness not including alcohol abuse, hepatitis B, hepatitis C, and sexually transmitted diseases. Tuberculosis is currently collected.

The new form provides a place to record the names of sex or needle sharing partners and spouses of the last 10 years.

The new case report form will be sent to selected physicians, health departments, hospitals, counseling and testing sites, rural health centers, disease intervention specialists, and the Department of Corrections facilities. The forms will also be on the ISDH website in Adobe Acrobat format at <http://www.in.gov/isdh/programs/hivstd/index.htm>. Click on Case Report Forms and select the adult or pediatric HIV/AIDS Confidential Case Report form. The completed forms must be mailed to:

Office of Clinical Data and Research  
Indiana State Department of Health  
2 N Meridian Street, 6-C  
Indianapolis IN 46209-6336

Business reply envelopes are available by calling 317-233-7406.

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## ***OUTBREAK SPOTLIGHT....***

“**Outbreak Spotlight**” is a regularly appearing feature in the *Indiana Epidemiology Newsletter* to illustrate the importance of various aspects of outbreak investigation. The event described below highlights the significance of laboratory surveillance and an awareness that disease agents know no borders.

### **Not In My Backyard? Outbreak of *Shigella dysenteriae* in Southern Indiana**

#### ***Background***

On February 20, 2002, a representative of the Indiana State Department of Health (ISDH) Laboratories notified the ISDH Epidemiology Resource Center that two specimens received from a hospital in County A had been confirmed positive for *Shigella dysenteriae*. *S. dysenteriae* is a species of *Shigella* bacteria that is extremely rare in the United States, and is most commonly acquired by travel to developing countries or contact with those from developing countries who are infected.

#### ***Epidemiologic Investigation***

The ISDH and the local health department of County A conducted a collaborative investigation of this outbreak to determine the location of the cases and determine if they were related. Upon learning that two cases were residents of neighboring counties, the local health departments of those counties were asked to participate in the investigation. The only common factor among all cases was having eaten at a common restaurant, Restaurant A, prior to illness. This restaurant is located in County A.

**Case 1.** A 61-year-old male County B resident had illness onset February 10. Symptoms included fever (102.5°F), bloody diarrhea, abdominal cramps, nausea, headache and weakness. The patient was hospitalized at a local hospital on February 11 and discharged on February 13. A stool specimen was collected on February 13, which revealed *Shigella dysenteriae* serotype 9 (see “Laboratory Results”). The patient was treated with Levoquin and recovered. The case reported eating a beef chimichanga with salsa and guacamole and salad at Restaurant A on February 7. No other risk factors were identified.



**Case 2.** A 28-year-old female County C resident experienced illness onset on February 11. Symptoms included fever (103°F), bloody diarrhea, abdominal cramps, nausea and gas. The patient sought medical attention but was not hospitalized. A stool specimen was collected on February 11 and revealed *Shigella dysenteriae* serotype 9. The patient was treated with antibiotics and recovered. The case reported eating a fajita at Restaurant A on February 9 or 10. No other risk factors were identified. Two other family members ate tortilla chips, salsa, and a menu item containing beef during the same meal. Both family members became ill with diarrhea approximately the same time as the case; however, they did not seek medical attention or submit stool specimens.

**Case 3.** A 76-year-old female County A resident became ill with diarrhea on February 10 or 11. The patient sought medical attention but was not hospitalized. A stool specimen was collected February 23 and tested positive for *Shigella dysenteriae* serotype 9. The patient was treated with antibiotics and recovered. The case reported eating a chicken quesadilla, rice, beans and a fruit drink at Restaurant A on February 8. She also reported swimming in a public pool approximately February 9; however, no other illnesses were associated with exposure to the pool. No other risk factors were reported. A friend of the case reportedly consumed chicken quesadilla (with no fruit drink) during the same meal. This individual did not become ill. The patient's employer reported eating dinner at Restaurant A on February 8 and had onset of diarrheal illness on February 10. This individual did not see medical attention or submit a stool specimen.

### ***Environmental Assessment***

A representative of County A Health Department contacted manager of Restaurant A on March 12 to review food preparation practices and inquire about employee illness. One restaurant employee was out of the country until March 18. The representative visited the establishment on March 19. One critical violation was noted, in that the drain for the hand sink in the dishwashing area was disconnected. This was to be repaired by March 22. A follow-up inspection on March 25 indicated that this violation had been corrected.

One employee reported arriving in the US from a trip to Mexico approximately February 7. Onset of vomiting occurred one day later, followed by intermittent diarrhea for approximately one week. This staff member did not seek medical attention, and the illness was self-limiting. No family members were ill. Although the employee did not prepare food directly, this staff member did help other employees serve food once it was prepared. The ill employee did work during the time period in question and did not miss any work due to illness.

None of the other employees had reportedly traveled out of the US or experienced illness. The only imported food used by the restaurant is avocado from Mexico, used in preparation of guacamole. However, the skins are removed during preparation. Managers and staff routinely instruct employees on the importance of hand washing. The restaurant has adequate, easily accessible hand washing facilities in work areas and restrooms. The staff was reminded of the importance of hand washing for employees, even if they only serve food.

### ***Laboratory Results***

No food samples were available for analysis.

Stool specimens were collected on all three cases identified and forwarded to the ISDH Laboratories for analysis. *Shigella dysenteriae* was cultured from all three specimens. The isolates were then forwarded to the Centers for Disease Control and Prevention (CDC) for serotyping, which identified the organism as serotype 9.

To determine if the strains were identical, and hence indicating a common source, the ISDH Laboratories performed pulse-field gel electrophoresis (PFGE) testing on the three isolates. The isolates from cases 2 and 3 showed 100% similarity and could be considered from a common source. The isolate from case 1 showed 90% similarity, differing by only one band. According to CDC, if two isolates match each other except for one band, there is a close relationship between the two isolates and a common source is very likely.



The employee who was ill submitted a stool specimen on March 20. The specimen tested negative for *Salmonella*, *Shigella*, *Campylobacter* and *E. coli* O157:H7.

## Conclusions

This investigation confirms that an outbreak of shigellosis occurred among patrons eating lunch at Restaurant A from February 7-9. The extremely short window of illness onset, the lack of subsequent cases after the outbreak, geographic distribution of the cases, and the rarity of the organism in the United States strongly suggest a common source exposure. Additional evidence is given by the laboratory results, indicating that the bacterial strains isolated from the cases were identical or closely related, also suggesting a common source. The only consistent exposure among the cases was eating at the restaurant.

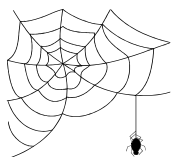
The causative agent of this outbreak was *Shigella dysenteriae*, serotype 9. This organism is commonly found in developing countries but rarely in the United States. *Shigella* bacteria are found only in humans (not in foods of animal origin) and are shed through stool. Symptoms of shigellosis include abdominal cramps, diarrhea (usually containing blood or mucus), nausea, vomiting, and fever, which may last up to a week or more. Without appropriate antibiotic treatment, those infected can shed the bacteria as long as one month.

Transmission occurs through direct or indirect fecal/oral contact, with ingestion of as few as 10-100 organisms. Bacteria can be transmitted through contaminated food or water or person-to-person contact. Foodborne shigellosis outbreaks usually occur when an infected food handler with inadequately washed hands prepares food that is served raw (i.e., salads, vegetables, etc.) or that is handled extensively after cooking (i.e., sliced sandwich meats, rolls, etc.). At least one employee at the restaurant experienced diarrheal illness compatible with shigellosis during the time in question. Although the staff member did not directly prepare food, the employee did assist other employees in serving food once it was prepared, and the employee did work while ill. This employee tested negative for *Shigella* bacteria; however, the stool specimen was collected approximately six weeks after illness onset, when shedding had likely ceased.

Anecdotal evidence indicates that there may have been more cases that were not reported. Case 2 reported two other family members who became ill with similar symptoms after sharing the same meal, and case 3 reported her employer also became ill after eating at the restaurant. These individuals were not tested, presumably attributing their illness to another cause. The ISDH wishes to commend the efforts of all local health departments that collaborated in this investigation.

In general, most outbreaks of shigellosis can be prevented by strictly adhering to the following safety practices:

1. Thoroughly wash hands with soap and water before preparing food, after using the restroom, and before eating.
  2. Exclude food handlers from working while ill with diarrhea and/or vomiting until symptoms have ceased.
  3. Use fresh gloves or newly washed utensils to handle ready-to-eat foods.
  4. Wash all fruits and vegetables before preparation, especially if served raw.
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## ***Wonderful Wide Web Sites***

### **ISDH Data Reports Available**

**The ISDH Epidemiology Resource Center has the following data reports and the Indiana Epidemiology Newsletter available on the ISDH Web Page:**

<http://www.statehealth.IN.gov> (under Data and Statistics)

Indiana Cancer Incidence Report (1990, 95,96)	Indiana Mortality Report (1999, 2000)
Indiana Cancer Mortality Report (1990-94, 1992-96)	Indiana Natality Report (1995, 96, 97, 2000)
Indiana Health Behavior Risk Factors (BRFSS) (1995-96, 97, 98, 99, 2000, 2001)	Indiana Induced Termination of Pregnancy Report (2000)
Indiana Hospital Consumer Guide (1996)	Indiana Combined Natality/Induced Termination of Pregnancy/Marriage Report (1998, 1999)
Indiana Marriage Report (1995, 97, 2000)	Indiana Infectious Diseases Report (1996, 97, 98, 99, 2000) (formerly Indiana Report of Diseases of Public Health Interest)
Indiana Maternal & Child Health Outcomes & Performance Measures (1988-97, 1989-98, 1990-99, 1991-2000)	Public, Hospital Discharge Data (1999)
Indiana HIV/STD Quarterly Reports	

## **HIV** Disease Summary

**Information as of November 30, 2002 (based on 2000 population of 6,080,485)**

### ***HIV - without AIDS to date:***

453	New HIV cases from December 2001 thru November 2002	12-month incidence	7.45 cases/100,000
3,675	Total HIV-positive, alive and without AIDS on November 30, 2002	Point prevalence	60.44 cases/100,000

### ***AIDS cases to date:***

453	New AIDS cases December 2001 thru November 2002	12-month incidence	7.45 cases/100,000
3,197	Total AIDS cases, alive on November 30, 2002	Point prevalence	52.58 cases/100,000
6,885	Total AIDS cases, cumulative (alive and dead)		

## REPORTED CASES

 of selected notifiable diseases

Disease	Cases Reported in November <i>MMWR</i> Week 44-48		Cumulative Cases Reported January - November <i>MMWR</i> Weeks 1-48	
	2001	2002	2001	2002
Campylobacteriosis	41	32	437	426
Chlamydia	1,439	1,616	14,597	15,901
<i>E. coli</i> O157:H7	8	16	81	72
Hepatitis A	6	2	93	43
Hepatitis B	5	8	48	51
Invasive Drug Resistant <i>S. pneumoniae</i> (DRSP)	14	15	167	150
Gonorrhea	752	710	6,519	6,873
Legionellosis	4	3	21	21
Lyme Disease	1	0	23	19
Measles	0	0	4	2
Meningococcal, invasive	3	3	37	32
Pertussis	2	25	80	128
Rocky Mountain Spotted Fever	0	0	1	3
Salmonellosis	44	41	490	465
Shigellosis	30	8	215	95
Syphilis (Primary and Secondary)	9	6	145	63
Tuberculosis	15	8	99	114
Animal Rabies	13	0	15 (15 Bats)	31 (30 Bats 1 Skunk)

**For information on reporting of communicable diseases in Indiana, call the *ISDH* Communicable Disease Division at (317) 233-7665.**

# **Indiana** ***Epidemiology*** **Newsletter**

The *Indiana Epidemiology Newsletter* is published by the Indiana State Department of Health to provide epidemiologic information to Indiana health professionals and to the public health community. We welcome input from our readers. Please direct questions and comments to Cheryl Thomas by calling (317) 233-7406 or e-mail at [cthomas@isdh.state.in.us](mailto:cthomas@isdh.state.in.us)

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